

ATTACHMENT 7

Sample Prior Authorization Request Form (PA/RF) for intensive in-home treatment services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

FOR MEDICAID USE — ICN						AT	Prior Authorization Number	
SECTION I — PROVIDER INFORMATION								
1. Name and Address — Billing Provider (Street, City, State, Zip Code) I.M. Provider 1 W. Wilson Anytown, WI 55555						2. Telephone Number — Billing Provider (XXX) XXX-XXXX		3. Processing Type 129
						4. Billing Provider's Medicaid Provider Number 56781234		
SECTION II — RECIPIENT INFORMATION								
5. Recipient Medicaid ID Number 1234567890			6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY			7. Address — Recipient (Street, City, State, Zip Code) 609 Willow Anytown, WI 55555		
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A				9. Sex — Recipient <input checked="" type="checkbox"/> M <input type="checkbox"/> F				
SECTION III — DIAGNOSIS / TREATMENT INFORMATION								
10. Diagnosis — Primary Code and Description 313.81 - oppositional disorder						11. Start Date — SOI		12. First Date of Treatment — SOI
13. Diagnosis — Secondary Code and Description N/A						14. Requested Start Date MM/DD/YY		
15. Performing Provider Number	16. Procedure Code	17. Modifiers	18. POS	19. Description of Service		20. QR	21. Charge	
12345678	H0004	HA HO	12	Behavioral health counseling and therapy, per 15 minutes		104	XXX.XX	
23456789	H0004	HA HN	99	Behavioral health counseling and therapy, per 15 minutes		35	XXX.XX	
12345678	99082	HA HO	99	travel		13		
23456789	99082	HA HN	99	travel		26		
<small>An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.</small>						22. Total Charges X,XXX.XX		
23. SIGNATURE — Requesting Provider 							24. Date Signed MM/DD/YY	
FOR MEDICAID USE						Procedure(s) Authorized:		Quantity Authorized:
<input type="checkbox"/> Approved <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div>Grant Date</div> <div>Expiration Date</div> </div>								
<input type="checkbox"/> Modified — Reason:								
<input type="checkbox"/> Denied — Reason:								
<input type="checkbox"/> Returned — Reason:								
SIGNATURE — Consultant / Analyst						Date Signed		